Medical Assistance
State North Carolina

Payment for Services - Prospective Reimbursement Plan for Nursing Care Facilities

.0101 REIMBURSEMENT PRINCIPLES

All certified nursing facilities participating in the North Carolina Medicaid Program are reimbursed on a prospective basis as set forth hereunder, except that state-operated facilities will be reimbursed their reasonable and allowable costs in accordance with the Medicare principles of reimbursement and with the provisions of Section .0103 and .0104 of this plan. This plan is developed in accordance with the requirements of 42 CFR 447 Subpart C - Payment for Inpatient Hospital and Long-Term Care Facility Services. Providers must comply with all federal regulations and with the provisions of this plan.

.0102 RATE SETTING METHODS

(a) A rate for skilled nursing care and a rate for intermediate nursing care is determined annually for each facility to be effective for dates of service for a twelve month period beginning each October 1. Each patient will be classified in one of the two categories depending on the services needed. Rates are derived from either filed, desk or field audited cost reports for a base year period to be selected by the state. Rates developed from filed cost reports may be retroactively adjusted if there is found to exist more than a two percent (2%) difference between the filed direct per diem cost and either the desk audited or field audited direct per diem cost for the same reporting period. Cost reports are filed and audited under provisions set forth in Rule .0104 of this Section. The criteria for determining the classification of each patient are presented in Appendix 1 of Attachment 3.1-A of the state Medicaid plan. The minimum requirements of the 1987 OBRA are met by these provisions.

(b) Each prospective rate consists of two components - a direct patient care rate and an indirect rate - computed and applied as follows:

(1) The direct rate is based on the Medicaid cost per day incurred in the following cost centers:

(A) Nursing,
(B) Dietary or Food Service,
(C) Laundry and Linen,
(D) Housekeeping
(E) Patient Activities,
(F) Social Services,
(G) Ancillary Services (includes several cost centers).

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(2) To compute each facility's direct rate for skilled care and intermediate care, the direct base year cost per day is increased by adjustment factors for price changes as set forth in Rule .0102(c).

(A) A facility's direct rates cannot exceed the maximum rates set for skilled nursing or intermediate nursing care. However, the Division of Medical Assistance may negotiate direct rates that exceed the maximum rate for ventilator dependent patients. Payment of such special direct rates shall be made only after specific prior approval of the Division of Medical Assistance. Effective October 1, 1990 through October 31, 1990 the maximum rates will not apply to the direct rates of state-operated facilities. The direct rates of state facilities will be calculated in accordance with provisions .0102(a), (b)(1), (b)(2)(B), (b)(4), and (c).

(B) A standard per diem amount will be added to each facility's direct rate, including facilities that are limited to the maximum rates, for the projected statewide average per diem costs of the salaries paid to replacement nurse aides for those aides in training and testing status and other costs deemed by HCFA to be facility costs related to nurse aide training and testing. The standard amount is based on the product of multiplying the average hourly wage, benefits and payroll taxes of replacement nurse aides by the number of statewide hours required for training and testing of all aides divided by the projected total patient days.

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(3) If a facility did not report any costs for either skilled or intermediate nursing care in the base year, the state average direct rate will be assigned as determined in Rule .0102(d) of this Section for the new type of care.

(4) The direct maximum rates are developed by ranking base-year per diem costs from the lowest to the highest in two separate arrays, one for skilled care and one for intermediate care. The per diem cost at the 80th percentile in each array is selected as the base for the maximum rate. The base cost in each array is adjusted for price changes as set forth in Rule .0102(c) of this Section to determine the maximum statewide direct rates for skilled care and intermediate care and weigh each by total patient days.

(5) Effective October 1, 1990, the direct rates will be adjusted as follows:

(A) A standard per diem amount will be added to each facility's skilled and intermediate rate to account for the combined expected average additional costs for the continuing education of nurses aides; the resident assessments, plans of care, and charting of nursing hours for each patient; personal laundry and hygiene items; and other non-nursing staffing requirements. The standard amount is equal to the sum of:

(i) the state average annual salary, benefits, and payroll taxes for one registered nurse position multiplied by the number of facilities in the state and divided by the state total of patient days;

(ii) the total costs of personal laundry and hygiene items divided by the total patient days as determined from the FYE 1989 cost reports of a sample of nursing facilities multiplied by the annual adjustment factors described in Rule .0102 (c)(4)(B) of this Section, and;

(iii) the state average additional pharmacy consultant costs divided by 365 days and then divided by the average number of beds per facility.

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(B) A standard amount will be added to the intermediate rate of facilities that were certified only for intermediate care prior to October 1, 1990. This amount will be added to account for the additional cost of providing 8 hours of RN coverage and 24 hours of licensed nursing coverage. The standard amount is equal to the state average hourly wage, benefits and payroll taxes for a registered nurse multiplied by the sixteen additional hours of required licensed nursing staff divided by the state average number of beds per nursing facility. A lower amount will be added to a facility only if it can be determined that the facility's intermediate rate prior to October 1, 1990 already includes licensed nursing coverage above eight hours per day. The add-on amount in such cases would be equal to the exact additional amount required to meet the licensed nursing requirements.

(C) The standard amounts in sub-paragraphs (2)(B), (5)(A), and (5)(B) will be retained in the rates of subsequent years until the year that the rates are derived from the actual cost incurred in the cost reporting year ending in 1991 which will reflect each facility's actual cost of complying with all OBRA '87 requirements.

(6) Upon completion of any cost reporting year any funds received by a facility from the direct patient care rates which have not been spent on direct patient care costs as defined herein are repaid to the state. This will be applied by comparing a facility's total Medicaid direct costs with the combined direct rate payments received for skilled and intermediate care. Costs in excess of a facility's total prospective rate payments are not reimbursable;

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(7) The indirect rate is intended to cover the following costs of an efficiently and economically operated facility:
   (A) Administrative and General,
   (B) Operation of Plant and Maintenance,
   (C) Property Ownership and Use,
   (D) Mortgage Interest.

(8) Effective for dates of service beginning October 1, 1984 and ending September 30, 1985 the indirect rates are fourteen dollars and sixty cents ($14.60) for each SNF day of care and thirteen dollars and fifty cents ($13.50) for each ICF day of care. These rates represent the first step in a two step transition process from the different SNF and ICF indirect rates paid in 1983-84 and the nearly equal indirect rates that will be paid in subsequent years under this plan as provided in this Rule.

(9) Effective for dates of service beginning October 1, 1985 and annually thereafter per diem indirect rates will be computed as follows:
   (A) The average indirect payment to all facilities in the fiscal year ending September 30, 1983 (which is thirteen dollars and two cents ($13.02)) will be the base rate.
   (B) The base rate will be adjusted for estimated price level changes from fiscal year 1983 through the year in which the rates will apply in accordance with the procedure set forth in Rule .0102(c) of this Section to establish the ICF per diem indirect rate.

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(C) The ICF per diem indirect rate shall be multiplied by a factor of 1.02 to establish the SNF per diem indirect rate. This adjustment is made to recognize the additional administrative expense incurred in the provision of SNF patient care.

(10) Effective for dates of service beginning October 1, 1989, a standard per diem amount will be added to provide for the additional administrative costs of preparing for and complying with all nursing home reform requirements. The standard amount is based on the average annual salary, benefits and payroll taxes of one clerical position multiplied by the number of facilities in the state divided by the state total of patient days.

(11) Effective for dates of service beginning October 1, 1990, the indirect rate will be standard for skilled and intermediate care for all facilities and will be determined by applying the 1990-91 indirect cost adjustment factors in Rule .0102(c) of this Section to the indirect rate paid for SNF during the year beginning October 1, 1989. Thereafter the indirect rate will be adjusted annually by the indirect cost adjustment factors.

(c) Adjustment factors for changes in the price level. The rate bases established in Rule .0102(b), are adjusted annually to reflect increases or decreases in prices that are expected to occur from the base year to the year in which the rate applies. The price level adjustment factors are computed using aggregate base year costs in the following manner:

(1) Costs will be separated into direct and indirect cost categories.

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(2) Costs in each category will be accumulated into the following groups:
  (A) labor,
  (B) other,
  (C) fixed.

(3) The relative weight of each cost group is calculated to the second decimal point by dividing the total costs of each group (labor, other, and fixed) by the total costs for each category (direct and indirect).

(4) Price adjustment factors for each cost group will be established as follows:
  (A) Labor. The expected annual percentage change in direct labor costs as determined from a survey of nursing facilities to determine the average hourly wages from RNs, LPNs, and aides paid in the current year and projected for the rate year. The percentage change for indirect labor costs is based on the projected average hourly wage of NC service workers.
  (B) Other. The expected annual change in the implicit price deflator for the Gross National Product as provided by the North Carolina Office of State Budget and Management.
  (C) Fixed. No adjustment will be made for this category, thus making the factor zero.
  (D) The weights computed in (c)(3) of this Rule shall be multiplied times the percentage change computed in (c)(4)(A),(B) and (C) of this Rule. These products shall be added separately for the direct and indirect categories.

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(E) The sum computed for each category in (c)(4)(D) of this Rule shall be the price level adjustment factor for that category of rates (direct or indirect) for the coming fiscal year.

(F) However, effective October 1, 1997 for fiscal year 1998, the price level adjustment factors calculated in (c)(4)(E) of this Rule shall be adjusted to 2.04% for direct rates and 1% for indirect rates, in order to produce fair and reasonable reimbursement of efficient operators.

(d) The skilled and intermediate direct patient care rates for new facilities are established at the lower of the projected costs in the provider's Certificate of Need application inflated from the projected opening date in the Certificate of Need application to the current rate period in which the facility is certified based on the price changes as set forth in Rule .0102(c) or the average of industry base year costs and adjusted for price changes as set forth in Rule .0102(c) of this Section. A new facility receives the indirect rate in effect at the time the facility is enrolled in the Medicaid Program. In the event of a change of ownership, the new owner receives the same rate of payment assigned to the previous owner.

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(e) Each out-of-state provider is reimbursed at the lower of the appropriate North Carolina maximum rate or the provider's payment rate as established by the state in which the provider is located. For patients with special needs who must be placed in specialized out-of-state facilities, a payment rate that exceeds the North Carolina maximum rate may be negotiated.

(f) Specialized Service Rates:

(1) Head Injury Intensive Rehabilitation Services -

(A) A single all-inclusive prospective prospective rate combining both the direct and indirect cost components can be negotiated for nursing facilities that specialize in providing intensive rehabilitation services for head injured patients as specified by criteria in Appendix 3 to Attachment 3.1-A of the State Plan. The rate may exceed the maximum rate applicable to other Nursing Facility services. A facility must specialize to the extent of staffing at least fifty percent (50%) of its nursing facility licensed beds for intensive head injury rehabilitation services. The facility must also be accredited by the Commission for the Accreditation of Rehabilitation Facilities (CARF).

(B) A facility's initial rate is negotiated based on budget projections of revenues, allowable costs, patient days, staffing and wages. A complete description of the facility's medical program must also be provided. Rates in subsequent years are determined by applying the average annual skilled nursing care adjustment factors to the rate in the previous year, unless either the provider or the State requests a renegotiation of the rate within sixty days (60) of the rate notice.

(C) Cost reports for this service must be filed in accordance with the Rules in .0104, but there will be no cost settlements for any difference between cost and payments. Since it is appropriate to include all financial considerations in the negotiation of a rate, a provider will not be eligible to receive separate payments for return on equity as defined in Rule .0105 of this Section.

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(2) Ventilator Services:

(A) Ventilator services approved for nursing facilities providing intensive services for ventilator dependent patients are reimbursed at higher direct rates as described in Rule .0102(b)(2)(A). Ventilator services are paid by combining the enhanced direct rate with the nursing facility indirect rate determined under rule .0102(b)(11).

(B) A facility's initial direct rate is negotiated based on budget projections of revenues, allowable costs, patient days, staffing and wages. Rates in subsequent years are determined by applying the nursing facility direct rate adjustment factor to the previous twelve month cost report direct cost.

(C) Cost reports and settlements for this service will be in accordance with Rule .0104 and return on equity is allowed as defined in Rule .0105.

(D) ~~A~~ single all-inclusive prospective per diem rate combining both the direct and indirect cost components can be negotiated for nursing facilities that specialize in providing intensive services for ventilator-dependent patients. The rate may exceed the maximum rate applicable to other Nursing Facility services. For ventilator services, the only facilities that are eligible for a combined single rate are small freestanding facilities with less than 21 Nursing Facility beds and that serve only patient requiring ventilator services. Ventilator services provided in larger facilities are reimbursed at higher direct rates as described in Rule .0102(b)(2)(A) of this Section.